IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF FLORIDA
TAMPA DIVISION

UNITED STATES OF AMERICA, ex rel. JAMES F. ALDERSON, Plaintiffs,	)	
v.	)	Case No. 99-413-CIV-T-23B
QUORUM HEALTH GROUP, INC., et al., Defendants.	)	

PLAINTIFFS' RESPONSE TO
DEFENDANTS' RULE 12(b)(6) AND RULE 9(b)
CONSOLIDATED MOTIONS TO DISMISS
IN RESPONSE TO PLAINTIFFS' COMPLAINT

Introduction

Plaintiffs' complaint contains straightforward false claims, false statements, and reverse false claims theories of False Claims Act ("FCA") liability. 31 U.S.C. §§ 3729(a)(1), (2) and (7). Plaintiffs allege that defendants (collectively "Quorum") followed a corporate policy or practice to include in their Medicare cost reports claims for reimbursement that Quorum knew would probably be lost if discovered by Medicare program auditors. To reduce the risk of discovery, Quorum's policy or practice was to withhold or conceal information related to these non-reimbursable cost items from Medicare auditors. Evidence of this withheld or concealed information is found in Quorum's reserve cost reports, work papers, and summaries.

For most of the thousands of separate cost items identified in Quorum's reserve cost report documents, Quorum was correct — such costs, which we highlighted in the exhibits to our Complaint, constitute false and inflated claims

for reimbursement that would have been disallowed if discovered by Medicare auditors. 31 U.S.C. § 3729(a)(1). In addition, the Complaint contains a false statements theory of FCA recovery. 31 U.S.C. § 3729(a) (2). The routine concealment of accounting information from Medicare auditors rendered the filed cost reports incomplete under applicable Medicare rules and regulations. Nonetheless, Quorum certified that the information contained in the filed cost reports was true, correct and complete. Each such certification was false and a violation of the FCA. The government was damaged by these false certifications whenever the complete information, reflected in Quorum's reserve cost report documents, would have revealed the non-reimbursability of the reserved cost. Finally, the Complaint contains a reverse false claims theory of FCA recovery. 31 U.S.C. § 3729(a) (7). Quorum had a legal obligation to disclose errors and omissions in its cost reports to the fiscal intermediary. 42 U.S.C. § 1320A-7b(a)(3).

The only unusual aspect of this case is the remarkable extent to which Quorum's own paperwork meticulously details the nature and extent of Quorum's fraud against the taxpayers. As described in the Complaint and its exhibits, the "reserve cost reports" and "reserve work papers" (which are often stamped "CONFIDENTIAL. Do Not Discuss or Release to Medicare Auditors"), list each inflated item filed on the cost reports, and in many cases explains why the claim is improper. For example, at paragraphs 269 through 278, the Complaint describes one false claim Quorum prepared for the Bascom Palmer Eye Clinic. The Clinic's

1991 cost report improperly used old 1990 maintenance statistics. The reserve report used the legally correct 1991 statistics and created a $39,823 reserve account. The work papers explained that the filed report had used the improper 1990 figures because they "materially increase reimbursement." Similarly, in the 1990 cost report Quorum prepared for Knox Community Hospital in Mount Vernon, Ohio, a false claim for $9,926 in Medicare reimbursement was included for depreciation on respiratory therapy equipment despite the fact (admitted in their reserve work paper) that defendants knew the equipment was "not . . . owned by [the] hospital." See id., Exhibit 99 (at Q 027970). A third example of the types of false claims at issue in this lawsuit relates to the cost report Quorum prepared in 1991 for Leesburg Regional Medical Center in Leesburg, Florida. There, Quorum knowingly overcharged Medicare $88,794 for Home Health Agency leased space that was "never occupied" (and thus not reimbursable as related to actual patient care). Id., Exhibit 100 (at Q 025309).

Quorum seeks to sidestep the task of explaining why the well-documented fraud that is alleged in the Complaint fails to state a claim under the False Claims Act. Instead, it asks the Court to dismiss a hypothetical complaint --- one that is predicated exclusively on "Quorum's practice of maintaining accounting reserves." No such Complaint is before the Court. Quorum's mischaracterization of the Complaint cannot hide the fact that plaintiffs' Complaint clearly alleges that over the last 15 years Quorum prepared and filed hundreds of Medicare cost reports

containing thousands of claims that Quorum's own documents show are false and inflated.

Motions to dismiss under Rule 12(b)(6) motions start from the premise that "a complaint should not be dismissed for failure to state a claim unless it appears beyond doubt that the plaintiff can prove no set of facts in support of his claims which would entitle him to relief." Conley v. Gibson, 355 U.S. 41, 45-46, 78 S.Ct. 99, 101-102 (1957). In ruling upon a motion to dismiss, a trial court thus is required to "construe the complaint broadly, accepting all facts pleaded therein as true and viewing all inferences in a light most favorable to the plaintiff." Public Citizen, Inc. v. Miller, 992 F.2d 1548 (11th Cir. 1993), citing Cooper v. Pate, 378 U.S. 546, 84 S.Ct. 1733 (1964); Oladeinde v. City of Birmingham, 963 F.2d 1481, 1486 (11th Cir. 1992), cert. denied, 507 U.S. 987, 113 S.Ct. 1586 (1993).

In their motions, defendants seek to turn these tenets on their head. Quorum seeks dismissal of the Complaint not on the basis of a favorable reading of what is actually pled but on a blatant misreading. Quorum repeatedly makes the false assertion that plaintiffs' theory of this case is that the creation of any reserve for a Medicare cost report inherently constitutes fraud. It then devotes more than 30 pages to knocking down the straw man it has erected. Any fair reading of the Complaint, however, shows that plaintiffs' claim is not that any creation of a cost report reserve inherently constitutes fraud. Rather, plaintiffs' allegation is that Quorum knowingly submitted false claims in its filed cost reports. It then reserved for their

effects, and in that process created a paper trail evidencing the fraud it committed. Quorum thus can find no comfort or protection in its unsupported assertion that others in the industry may have used accounting reserves in association with legitimate claims, policies and practices.

The Allegations of the Complaint

Preparing cost reports for federal health care reimbursement is a complicated process that requires special expertise. In essence, however, the nature of defendants' fraud is quite simple. Quorum used its cost-reporting expertise to game federally funded health care reimbursement systems.[1/] Quorum accomplished this, first, by including in cost reports that it prepared and filed claims that it knew would "probably" be disallowed if discovered by auditors, see, e.g., Complaint , ¶¶ 69 & 75, and, second, by making efforts to ensure that the facts that would lead to the probable disallowance remained concealed from program administrators and auditors. See, e.g., id., ¶¶ 77, 86, 172. Quorum rarely created reserves to protect against financial consequences that might result from good faith uncertainty about how much federal reimbursement was properly due.[2/] In the vast majority of

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[1/] These include Medicare (which provides medical benefits based on age, disability or affliction with end-stage renal disease), Medicaid (through which the federal government and the states provide medical benefits primarily to the poor and disabled), and TRICARE Management Activity/CHAMPUS (which provides medical benefits to the spouses and unmarried children of active duty and retired armed service members). See Complaint, ¶¶ 20, 94, & 110.

[2/] Properly created reserves would include, for example, instances in which Quorum filed a cost claim “under protest” and thus flagged for the government issues where

instances, Quorum used reserves to hedge its bet about what portion of the hidden overcharges it knowingly submitted ultimately would be caught and reversed.

In the general allegations of the Complaint, see ¶¶ 1-5 & 19-320, plaintiffs have sought to accomplish four principal tasks: First, to set forth the basic principles of the False Claims Act and cost report reimbursement that one must know to understand plaintiffs' claims. Second, to provide an overview of defendants' fraud and then a detailed analysis (with specific examples) of the most typical types of false claims that defendants submitted in their cost reports. Third, through use of Quorum's own documents (which are attached as exhibits to the Complaint and incorporated into the body of that pleading by reference), to identify with particularity the currently-known universe of specific false claims that Quorum submitted. And fourth, to provide plaintiffs' basis -- founded upon Quorum's documented policy and practice of routinely submitting false claims in cost reports it prepared and/or filed -- for alleging that similar misconduct occurred with respect to Quorum-prepared cost reports for which reserve documentation has not yet been made available to plaintiffs for review.

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reimbursement had been disallowed in the past but with respect to which Quorum wished to preserve its right to appeal then-applicable reimbursement standards. They could also include items such as blanket reserves taken solely as a precaution against the risk that auditors will find mistakes or problems in a provider's reimbursement claims that were unknown to Quorum at the time the cost report was prepared and submitted.

A. Basic Legal Principles and Mechanics of Federal Reimbursement and Cost Reporting.

To provide background information necessary to understand the context in which defendants' fraudulent conduct occurred, plaintiffs explain basic legal principals and the mechanics of federal reimbursement and cost reporting in Paragraphs 19-67 of the Complaint:

Until 1983, reimbursement for payments to hospitals and other institutional health care providers pursuant to "Part A" of the Medicare program was based upon the "reasonable cost" of inpatient services provided to Medicare beneficiaries. Providers were reimbursed for the actual costs they incurred, provided that they fell within certain cost limits. As a result, however, as hospital costs escalated, so did the amount Medicare was required to reimburse. See Complaint, ¶¶ 20-21.

In response to its concern about this trend, Congress in 1983 revised the system for reimbursing inpatient hospital care by establishing the prospective payment system ("PPS"). Under PPS, most hospitals (including defendants') were ultimately to be paid entirely on the basis of fixed rates that varied with the type and category of hospital treatment received. Outpatient hospital costs and the costs of certain hospital-based subproviders (such as home health agencies), however, were not included in the PPS system and continued to be reimbursed on a reasonable cost basis.

For hospital capital costs, the PPS system was not implemented in its entirety all at once. Rather, it was phased in, so that Part A Medicare capital costs were

paid 10 percent based upon the PPS system in cost-reporting years beginning on or after October 1, 1991, and 90 percent based upon costs actually incurred. An additional 10 percent of such costs have been paid through the PPS system each year since. As a result of the introduction of the PPS system, in order to increase Medicare reimbursement, hospitals had a financial incentive during the period relevant to plaintiffs' Complaint to characterize costs as outpatient costs or capital expense items. See id., ¶¶ 22-26.

Cost-based reimbursement is paid providers on the basis of information reported by them annually in cost reports submitted by them to "fiscal intermediaries" (usually insurance companies) that have contracted with the government to process, pay, and -- in some cases -- audit claims submitted to the Medicare program. Payments are made initially through "interim payments" paid throughout the year based on the number of Medicare patient stays at the hospital. A final adjustment is then made annually based on the cost report information submitted by hospitals. These fiscal year-end adjustments harmonize the amounts that had been paid through interim payments to the year-end cost results providers report. Id., ¶¶ 27-30. Quorum's year-end cost reports, which are filed with the government's fiscal intermediaries, are the documents that contain -- imbedded in the reported cost figures -- the false claims at issue in this litigation. See, e.g., id., ¶ 55.

The Complaint explains the mechanics of how Medicare cost reports are pre-

pared, and the types of cost information they contain. See id., ¶¶ 33-46. It then describes the certifications providers sign when filing cost reports. Through these certifications, providers attest to the truthfulness, correctness, and completeness of the cost reports they have submitted. Id., ¶¶ 47-52. "Each of the cost reports prepared and submitted by Quorum on behalf of its owned or managed hospitals, included the following certification:

> to the best of my knowledge and belief, [the cost report] is a true, correct, and complete report prepared from the books and records of the provider in accordance with applicable instructions, except as noted."

Id., ¶ 59 (emphasis and parenthetical information appear as in the Complaint).

Such certifications are important because the Medicare program depends heavily upon the good faith of providers completing their cost reports. It is common knowledge in the health care industry that the government lacks adequate resources to conduct full-scope audits on each of the over 35,000 providers nationwide, including hospitals, which file cost reports with Medicare each year. Id., ¶ 52.

The Complaint quotes and highlights specific Medicare regulations and Provider Reimbursement Manual ("PRM")[3/] instructions that defendants knew and violated, notwithstanding the certifications their employees signed. See id., ¶¶ 15-16, 59, 61-67. Included among these are the procedures providers must follow for

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[3/] The PRM contains the Health Care Finance Administration's ("HCFA") instructions to providers on reimbursement issues.

filing a claim “under protest.” While it is permissible to include claims within a filed cost report claims for presumptively nonallowable reimbursement, when such an approach is utilized the cost report must be filed under protest, and "the disputed item and amount for each issue must be specifically identified in footnotes to the settlement worksheet and the fact that the cost report is filed under protest must be disclosed." Id., ¶ 65, quoting PRM (Part II), § 115. As is discussed more fully below, Quorum did precisely the opposite. Rather than flagging, protesting, and accurately documenting cost items it had included in its filed cost reports that were "probably" unallowable, Quorum secretly mingled them among other claims and kept its documentation[4] regarding the true nature and effect of its false claims in separate files that it instructed its employees not to discuss with or show Medicare auditors. See, e.g., id., ¶¶ 71, 73-75, 77, 82 & 172. The result was that defendants concealed from Medicare crucial “information contained in their reserve sets of cost report records" that was necessary to permit a full and fairly informed assessment of defendants' reimbursement claims. Id., ¶ 5 (emphasis added). Medicare regulations require that providers "'must furnish such information to the intermediary as may be necessary to (I) Assure proper payment by the program....'" See id., ¶ 61, quoting 42 C.F.R. § 413.20(d) (emphasis supplied in the Complaint).

The PRM further provides that when disputed items are included in a cost

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[4] Such documentation consisted of reserve cost reports and their associated reserve summaries and work papers. See Complaint, ¶ 73.

report, the provider "must submit, with the cost report, copies of the working papers used to develop . . . estimated adjustments in order for the intermediary to evaluate the reasonableness of the methodology for purposes of establishing whether the cost report is acceptable." Id., quoting PRM (Part II), § 115.1. Providers are also warned, "If you deliberately include cost, without disclosing the fact, in the provider cost report that is nonreimbursable under the regulations you are subject to those provisions concerning suspected fraud or abuse." Id., quoting PRM (Part II), § 115.2.

These duties are supplemented by ones imposed by a criminal statute, 42 U.S.C. § 1320A-7b(a)(3), which requires anyone who learns that they have been over-paid for providing health care to Medicare patients to disclose the over payment. Complaint, ¶ 67.[5/]

B. Overview and Typical Examples of Defendants' Fraudulent Cost-Reporting Policies and Practices.

Quorum's fraudulent cost-reporting and reserve practices were adopted from its corporate predecessor, HCA Management Company. HCA directed that, in preparing federal reimbursement cost reports, its employees utilize "an aggressive interpretation of the Law, Regulation, and Policy." Reserves were then limited to "items, sophistications, etc., which upon discovery, examination or other future

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[5/] Similar detail is subsequently provided in the Complaint regarding how Medicare cost-reporting is tied to and affects provider reimbursement under the Medicaid and TRICARE/CHAMPUS programs. See id., ¶¶ 94-108 & 109-124.

event will 'probably' be lost." Complaint, ¶¶ 68-69 & 74-77. Defendants' reserve policy also provided that money should not be withheld from reported income of the hospital if there was only a slight possibility that the cost at issue would be discovered and disallowed: "No reserves should be provided where the possibility of loss is remote." Id., ¶ 69. These allegations provide the backdrop against which to judge the significance of Quorum's reserves. Together with Quorum's noted practice of (1) "routinely . . . conceal[ing] from the fiscal intermediaries and HCFA" the specifics of cost report claims for which it had created reserves, see id., ¶ 77, and (2) disclosing through "protest" "only those reserve items contrary to clearly expressed program policy for which Quorum wished to protect its appeal rights," id., ¶ 76, these directives make clear that Quorum was not interested in assuring that there had been a full, fair, and open adjudication of its reimbursement claims. Quorum's principal reason for creating reserves thus was not to insure its hospitals were protected from the effects of good-faith disagreements with fiscal intermediaries and HCFA, but to hedge its bets on items it had "aggressively" -- and secretly -- included in cost reports despite the fact that they would "probably" be disallowed if discovered. As the Complaint explains in detail, such practices violated each component of the certifications that Quorum owned and managed hospitals had signed, representing that each cost report defendants prepared and filed was "a true, correct, and complete report prepared from the books and records of the provider in accordance with applicable instructions, except as noted." Id., ¶¶ 59 &

83-93.

Because of the expansive scope of defendants' misconduct,[6/] pleading the "circumstances constituting fraud" with FRCP 9(b)'s requisite particularity while remaining responsive to the requirement of Rule 8 that the Complaint contain "a short and plain statement of the claim showing that the pleader is entitled to relief" presented plaintiffs with a unique challenge. To identify the specific hospitals whose cost reports are at issue in this litigation and the relevant cost report years, plaintiffs attached to the Complaint tables that provided all such information, and much more. See Complaint, ¶¶ 78-82, 125-126 and Exhibits 4 & 5 thereto. Among the information contained in those tables is (1) the names and titles of the people known to be responsible for preparing, reviewing, and signing each identified cost report and any known associated reserves, (2) an indication whether the Medicare cost report was filed in support of Medicaid claims as well, and (3) the dates upon which the cost reports were filed and the reserve cost reports prepared. As noted in the Complaint, where such details relating to any specific cost report were not included in those tables, the missing information remains entirely within the defendants' and/or their owned or managed hospitals' control. Id.

Having identified with great specificity what filed and reserve cost reports are

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[6/] Although plaintiffs have never tabulated the total number of cost report reserve items highlighted as actionable items in the exhibits incorporated into the Complaint, according to the defendants there are more than 2,800 such items marked.

at issue in this litigation and who prepared them, the Complaint focuses next on identifying those claims exposed by defendants' reserve summaries and work papers that plaintiffs allege violate the FCA.[7]

Because a large percentage of the actionable false claims identified in Quorum's reserve papers fall into similar categories of abuse, plaintiffs began by providing a detailed look at the nine major types of improper cost claims defendants have submitted. See id., ¶¶ 130-131, 132-310.[8] For each area, the Complaint explains the applicable reimbursement principles and how defendants' claims violate those principles. Id. Detailed explanations are provided with examples from defendants' client hospitals for each area of fraud described. These examples

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[7] That plaintiffs "make no claim" for items intentionally left unhighlighted in Exhibits 32-196 of the Complaint, see id., ¶ 313, is not an admission that the claims to which the unhighlighted items relate were properly made. While some -- like claims identified as "protested items" noted in the filed cost report -- appear to have been properly noted and identified in the filed cost report, the majority of these items have been excluded because of changes in the law, because the claims related to settlement data that would be adjusted by intermediaries automatically and thus that may not have resulted in actual damages, or other such considerations.

[8] These include: (1) billing for non-allowable costs (including such items as personal comfort items, advertising costs, non-allowable guest meals, non-allowable physician billing costs, and non-allowable legal fees); (2) improper treatment of capital-related costs (such as knowing use of improper depreciation methods or improper accounting for capital interest expenses); (3) submission of unsupported claims for hours billed by hospital-based physicians; (4) fraudulent shifting of inpatient costs to outpatient billing centers; (5) fraudulent shifting of hospitals' overhead costs to hospital-based subproviders; (6) knowingly claiming for ineligible bad debts; (7) fraudulent manipulation of provider statistics to inflate reimbursement; (8) knowingly billing for costs attributable to non-reimbursable cost centers; and (9) improperly combining hospital cost centers for the specific purpose of inflating Medicare reimbursement. Id.

cover twenty-three (23) false claims submitted on behalf of ten (10) hospitals in fifteen (15) different cost reports. Id. When combined with the exhibits upon which the written analysis is based, there can be no genuine dispute that plaintiffs' description of these matters greatly exceeds the notice requirements of the Rules.

C. Identification of the Specific False Claims that are Currently Known Based Upon Information and Documentation Available to Plaintiffs to Date

Providing the level of detail outlined above for just twenty-three (23) cost report reserve items required 178 paragraphs of allegations extending over thirty-two (32) pages of the pleading. Id. At that rate, it would take more than 3,895 pages of pleading to provide similar levels of detail with respect to the more than 2,800 reserve items that defendants have counted among the actionable items plaintiffs highlighted in Exhibits 32-196 of the Complaint. Instead, plaintiffs used defendants' own reserve documents to put them on notice of all currently-known false claims. See Complaint, ¶¶ 311-13 and Exhibits 32-196 thereto. For ease of reference, the exhibits are arranged by hospital and affected cost reporting year, and an index of exhibits is provided. Id.

The benefits of such an approach to the defendants are obvious. First, because the false claims at issue are identified by reference to the defendants' own documents, there could be no risk that plaintiffs' efforts to summarize the content of those materials would somehow obscure the focus of their inquiry. Defendants themselves identified the challenged aspects of their filed cost reports when they

created the specific reserve entries for which they are now being required to answer. More straightforward notice of the allegations against them is difficult to imagine.

Second, because the highlighted reserve work papers and summaries indicate on their face the hospital and relevant cost-reporting year(s), Quorum is put on notice of the specific filed cost report(s) in which each alleged false claim appeared. (Reference to the filed cost reports themselves would be far less helpful, because the claims appear in such reports only as unspecified components of cost data totals entered into the reimbursement form.) This approach also identifies in defendants' own words the specific cost reimbursement items at issue.

In almost every instance, defendants have also calculated on the pages plaintiffs have highlighted at least the amount of Medicare (and, often, also the amount of Medicaid) reimbursement dollars at stake. Indeed, the documents were originally created to quantify the dollar amount of exposure created by the false claims. See id., at ¶¶ 68-77. Just as when they were originally prepared, defendants' reserve documents pinpoint the specific reimbursement claims that defendants knew all along were improper and subject to probable loss. No doubt, that is why defendants' employees were instructed not to show or discuss these documents with Medicare auditors. See, e.g., id., Exhibit 13, at Q027089 (which, like many other reserve documents included among the exhibits to the Complaint, is stamped: "CONFIDENTIAL. Do Not Discuss or Release to Medicare Auditors.").

In conjunction with (1) plaintiffs' allegations regarding Quorum's policies and practices with respect to filing Medicare cost reports and creation of cost report reserves and (2) the detailed explanations of the major categories of defendants' false claims that appears at paragraphs 125-310 of the Complaint, the documents attached as Exhibits 32-196 to the Complaint also provide fair notice of the basis for plaintiffs' allegation that the highlighted reserves pinpoint false claims that were submitted in the cost reports Quorum prepared and filed.

Exhibits 32-196 consist of the reserve summaries and work papers that defendants created to identify and value claims contained in their filed cost reports that -- as stated in their own reserve policies -- defendants knew would probably be lost if discovered. Generally, the descriptions provided on the face of those documents give a good indication of the nature of the issue for which a reserve has been created. It is clear from reviewing the exhibits that most of Quorum's reserves fall within the major categories that were discussed in detail in paragraphs 32-196 of the Complaint.

There are, of course, items plaintiffs have marked as actionable in the exhibits that do not fall clearly within the major categories of defendants' false claims that are discussed in detail the Complaint. In those instances, the descriptions and information about the reserves that are included in the exhibits -- together with Quorum's stated reserve policies -- form plaintiffs' basis for alleging upon information and belief that the reserves evidence false claims.

Defendants specifically directed that "[c]ost reports should be filed requesting maximum reimbursement based on an aggressive interpretation of the Law, Regulation, and Policy," id., ¶¶ 68 & 73 (quoting defendants' reimbursement policy guidelines) (emphasis added). Defendants also instructed their cost-reporting personnel to create reserves only for "items, sophistications, etc., which upon discovery, examination or other future event will 'probably' be lost." id., ¶¶ 69 & 75 (quoting defendants' reimbursement policy guidelines)(emphasis added). Combined with Quorum's practice of concealing from Medicare facts and information which would create a high risk of disallowance, see, e.g., id., ¶¶ 5, 70, 76-77, 172, 187-188, these Quorum policies create a strong presumptive case that a false claim was made whenever Quorum took a reserve. In most cases, the Quorum documentation that is attached as exhibits to the Complaint provides ample notice of the nature of the cost item for which they are reserving. Even where defendants' original documentation is less clear, Quorum's pattern and practice of submitting false and inflated claims certainly suggest that ambiguous reserve entries will be proven false claims after full discovery has been completed. Until discovery can be conducted, the exhibits to the Complaint provide plaintiffs' best current information about the specific nature of each reserve item listed. Further details related to such items remain for the time being in the exclusive control of defendants and their client hospitals.

D. All Hospitals Owned or Managed by Defendants Submitted Cost Reports that Included False Claims or Statements, Whether or Not Reserves Relating to Such Reports Are Currently Available for Review

Finally, plaintiffs allege that defendants included false claims in all the cost reports that they have prepared and filed for their owned or managed hospitals for cost years ending on or after January 1, 1985, through cost years ending on December 31, 1995. See Complaint, ¶¶ 314-316. The basis for this allegation rests in Quorum's stated reserve policies and in its pattern and practice of implementing its fraud that is evident from the documentation currently available to plaintiffs. Because defendants and/or their client hospitals have not yet produced -- and thus plaintiffs have not had an opportunity to review -- all of reserve papers defendants prepared that are relevant to their claims, there is reason to believe that a great many specific false claims that were included in cost reports defendants prepared and/or filed remain to be exposed.

The lists contained in Exhibits 4 & 5 of the Complaint summarize what is currently known to plaintiffs regarding hospitals and cost-reporting years for which defendants prepared and filed cost reports. See Complaint, ¶¶ 78-82. All reserve summaries that are currently available to plaintiffs and that relate to the cost reports listed in Exhibits 4 & 5 to the Complaint appear in Exhibits 32-196 to that document. See id., ¶¶ 131, 311-316.[9/] Review of these materials demonstrates defendants'

[9/] At the time the Complaint was filed, any and all further information identifying the amount and specific nature false claims contained cost reports that defendants

reserve practices remained true to their stated reserve policies. The information currently available to plaintiffs and incorporated into the Complaint thus shows at least three crucial things: (1) that defendants routinely included in the cost reports they prepared and filed on behalf of owned and managed hospitals claims that they knew were improperly presented, (2) that defendants knew the proper manner in which such issues should have been treated on the filed cost reports (as demonstrated by their ability to identify relevant information and to make the correct reimbursement calculations for purposes of establishing their secret reserves), and (3) that these reserve work papers make clear to people familiar with such accounting documents that relevant information was withheld from Medicare and that the filed claims at issue in this lawsuit probably — and often certainly -- would have been disallowed had the concealed information been disclosed. See id., Exhibits 32-196. Withholding such information violates Medicare regulations and reimbursement instructions and guidelines. Plaintiffs therefore are well justified to include among their allegations the assertion that defendants' misconduct extended to all hospitals and cost reports in which Quorum controlled the submission of cost reports, whether or not reserve documentation relating to specific cost reports that Quorum prepared are currently available for plaintiffs' review. See id., ¶¶ 314-316.

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prepared which is not summarized in the above-cited exhibits remained exclusively in the defendants' and/or their client hospitals' control. See id., ¶¶ 79, 82.

Argument

I. THE COMPLAINT'S FALSE CLAIMS ACT ALLEGATIONS STATE CLAIMS FOR RELIEF

A. Plaintiffs' Allegations Track the Elements of the False Claims Act and the Principles Stated by the Eleventh Circuit in United States v. Calhoon

Interpreted, as they must be, in the light most favorable to plaintiffs,[10/] there can be no genuine dispute that the False Claims Act allegations set forth in the Complaint state proper claims for relief. Plaintiffs' FCA allegations directly track the elements of the statute: (1) By filing, and by causing others to file and present, cost reports claiming Medicare, Medicaid, and/or TRICARE/CHAMPUS reimbursement for cost items that defendants knew "probably" would be disallowed if discovered, by concealing from the government and its agents factual information regarding the probable disallowance of reimbursement claims submitted, and by falsely certifying that the cost reports that they were submitting were "true, correct, and complete report[s] prepared from the books and records of the provider in accordance with applicable instructions, except as noted" defendants violated the liability provisions of 31 U.S.C. § 3729(a)(1); (2) By knowingly making, using, and causing others to make or use filed cost report work papers that did not properly disclose or account for facts material to their asserted right to payment, and by signing or causing others to sign false certifications in support of their owned and client hospitals'

[10/] See, e.g., Conley, 355 U.S. at 45-46, 78 S.Ct. at 101-102; Scheuer v. Rhodes, 416 U.S. 232, 94 S.Ct. 1683 (1974).

claims for cost-based reimbursement in order to get false or fraudulent reimbursement claims paid or approved by the United States Government, defendants violated the liability provisions of 31 U.S.C. § 3729(a)(2); and (3) By knowingly making, using, and causing others to make or use such false cost reports, work papers, and false certifications to conceal, avoid, or decrease their owned and managed hospitals' obligations to return excess "interim payments" at the time that year-end adjustments to hospital cost-reimbursement are made on the basis of such documents, see Complaint, ¶ 29, defendants violated the disclosure duty identified in 42 U.S.C. § 1320A-7b(a)(3) and the liability provisions of 31 U.S.C. § 3729(a)(7). See Complaint, ¶ 67. Because the Complaint alleges that all that conduct described above has occurred, there is no basis for defendants' assertion that plaintiffs have failed to state a claim upon which relief can be granted.

The wrongful nature of the type of conduct alleged in the Complaint was recognized by the Eleventh Circuit in United States v. Calhoon, 97 F.3d 518 (11th Cir. 1996), cert. denied, 118 S.Ct. 648 (1997). There, the court upheld the criminal conviction of a hospital employee charged with violating 18 U.S.C. § 1001 (false statements) and 18 U.S.C. § 1341 (mail fraud) by signing and mailing or causing others to sign and mail Medicare cost reports claiming amounts that he knew were not reimbursable. Much like Quorum, Calhoon tried to excuse his conduct by pointing to the flexibility and discretion inherent in the Medicare reimbursement system. Compare, e.g., Calhoon, 97 F.3d at 529 to Quorum's Consolidated Brf., at

17-20. The Eleventh Circuit gave little credence to such assertions, stating:

> While it is true that a provider may submit claims for costs it knows are presumptively nonreimbursable, it must do so openly and honestly, describing them accurately while challenging the presumption and seeking reimbursement. Nothing less is required if the Medicare reimbursement system is not to be turned into a cat and mouse game in which clever providers could, with impunity, practice fraud on the government. As Wheeler, the government's expert witness testified, if a provider disagrees with the intermediary, with the intermediary's past decisions, with the instructions or guidelines in the Provider Reimbursement Manual, or with the regulations, the provider must file the cost report "under protest." . . . Calhoon testified that he understood [the protest system] and that he in fact used this system for other types of costs claimed in the very cost reports at issue here. Yet he failed to follow this procedure for [the reimbursement items on which his convictions were based].
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> In sum, Calhoon's argument misses the crux of his offense: the filing of reports intended and designed to deceive and mislead auditors for the purpose of obtaining reimbursement of costs Calhoon knew to be at least presumptively, if not clearly, nonreimbursable. Available time and resources do not permit audit of more than a fraction of the cost reports filed. Calhoon's filing of reports claiming costs that were at least presumptively nonreimbursable while concealing or disguising their true nature was a deliberate gamble on the odds that they would not be questioned.
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> The evidence amply sustains the findings of falsity.

97 F.3d at 529 (internal citation omitted).

Plaintiffs' allegations amply demonstrate that defendants knowingly submitted claims that were nonallowable and inconsistent with proper cost reporting

practices. It is thus clear why those claims violate the False Claims Act.

B. Defendants' Failed to Address the Actual Allegations of the Complaint or Adequately Distinguish This Case from United States v. Calhoon

Rather than addressing the actual allegations against them, defendants launch a lengthy assault against straw-men allegations that appear nowhere in the Complaint. More than eight pages of argument are dedicated to rebuffing the concept, never advanced by plaintiffs, that any use by hospitals of accounting reserves inherently violates the False Claims Act. See Quorum's Consolidated Brf., at 13-23. Because Quorum's arguments are premised on the incorrect notion that the existence of reserves alone forms the basis of plaintiffs' complaints, their analysis of legitimate reasons why reserves sometimes may be justified — and, indeed, even prudent or necessary — provides no genuine support for their current motions. The existence of reserves is not the issue in this case. It is how they were used by Quorum and what they tell us about what Quorum did in preparing and submitting filed cost reports that matters.[11/] And those are the considerations Quorum has chosen to side-step and ignore in its current motions.

[11/] For similar reasons, defendants' assertion, Quorum's Consolidated Brf., at 6, n. 3, that the Government was long on public notice that they maintained reimbursement reserves adds no weight to their defense. Even for those who ever had reason study Quorum's Form 10-K statements carefully enough to recognize that they refer to reserves could discern nothing from those statements that reveals the policies and practices that form the core of plaintiffs' allegations in this lawsuit. Because it is not the creation of reserves per se that constitutes a FCA violation, notice of their existence alone provides little or no insight into whether improper conduct has occurred.

Recognizing the difficulty Calhoon creates for their defense, defendants likewise seek to distinguish that case based on distortions of fact and law. Quorum argues that the current case is different from Calhoon because (1) they are accused of a company-wide scheme to defraud rather than of actions of a single employee, (2) Calhoon was charged criminally for making false statements rather than for civil violations of the FCA, (3) Calhoon was accused of affirmatively misrepresenting the nature of certain reimbursement claims whereas Quorum purportedly is not, and (4) Calhoon does not hold that the use of reserves or nondisclosure of reserve work papers constitutes presenting a false or fraudulent claim (an assertion that, yet again, totally misstates plaintiffs' theory of the case). See Quorum's Consolidated Brf., at 21-22.

Quorum's first two points identify factual distinctions that in no way mitigate the legal principles quoted above. The fact that Quorum is accused of executing a much more expansive scheme to defraud than did Calhoon -- or that he was charged criminally for such misconduct rather than only civilly -- are hardly factors that aid Quorum's defense. Engaging in a much wider pattern of misconduct cannot somehow transform the scheme into legitimate behavior for which no civil remedy for fraud exists.

Quorum's second two efforts to distinguish Calhoon are factually and legally inaccurate. Quorum's assertion that, unlike Calhoon, it has not been charged with misrepresenting the types of cost items it submitted simply is not true. Quorum has

been charged with such misconduct. For example, Paragraphs 182-183 of the Complaint allege that in 1992 Quorum misrepresented non-capital operating room, maintenance and supply costs as capital-related equipment costs and reserved for the difference in reimbursement that would result if the mischaracterization was discovered. Likewise, at paragraphs 292-296 of the Complaint, it is alleged that in 1992 Quorum knowingly categorized non-reimbursable costs associated with a medical office building as costs associated with reimbursable patient care and, as a result, received $53,393 to which it knew it was not entitled. Indeed, explicit and implicit misrepresentations are at the heart of virtually all Quorum's alleged misconduct. No less so than the conduct in Calhoon, such conduct deceives "Medicare auditors by deliberately misstating the types of costs claimed." See Quorum's Consolidated Brf., at 21-22.

Quorum also misses the mark in its apparent effort to distinguish misrepresentation about "types" of costs being claimed from misrepresentations about the proper amount of such costs. Id. Neither the False Claims Act nor the court in Calhoon makes any such distinction. In Calhoon, the Eleventh Circuit unequivocally stated, "[t]he cost report filing process requires providers to identify accurately both the nature and the amount of costs claimed...." 97 F.3d at 523 (emphasis added). Providers get no free pass for misrepresenting "only" the proper amount of reimbursement to which they are due.

The Calhoon court condemns conduct that is, at its roots, indistinguishable

from the conduct alleged in plaintiffs' Complaint. To knowingly submit claims in a Medicare cost report that are at least presumptively nonreimbursable, without utilizing the protest system to fully and fairly reveal the nature and amount of the costs being claimed, is to submit claims that are false. Calhoon, 97 F.3d at 529. Such conduct is unlawful under both 18 U.S.C. § 1001 and the civil False Claims Act. By holding that the evidence cited in that case "amply sustains the findings of falsity," 97 F.3d at 529, Calhoon leaves no genuine room for doubt that the essentially identical conduct alleged in plaintiffs' Complaint in this case states a valid claim for submission of false claims in violation of the civil False Claims Act.

C. Quorum Failed to Comply with the "Protest Rule"

Calhoon also demonstrates the lack of merit to defendants' effort to minimize and evade responsibility for its non-compliance with the "protest rule." See Quorum Consolidated Brf., at 26-28. That Quorum followed correct procedures to protest regulations or intermediary interpretations of the law on some occasions does not permit Quorum to ignore the protest procedure on other occasions. As noted in the passage quoted at length above, the defendant in Calhoon also correctly used the protest procedures when it suited his purposes. The Eleventh Circuit understood, however, that such facts only confirm that he acted with culpable knowledge and intent when he failed candidly to utilize protest procedures with respect to other presumptively nonreimbursable claims he buried in filed cost reports. See Calhoon, 97 F.3d at 529 ("Calhoon testified that he understood [the protest system] and that

he, in fact, used this system for other types of costs claimed in the very cost reports at issue here. Yet he failed to follow this procedure for the [cost items upon which his convictions rested.]")

Use of the "protest rule," moreover, is not restricted (as Quorum suggests) to instances in which there is an "application of Medicare regulation" which the hospital "wishes" to dispute judicially. See Quorum Consolidated Brf., 27-28. Whenever presumptively nonreimbursable costs have been claimed because "a provider disagrees with the intermediary's past decisions, with the instructions or guidelines in the Provider Reimbursement Manual, or with the regulations, the provider must file the cost report 'under protest.'" Calhoon, 97 F.3d at 529 (emphasis added). It is not valid simply to ignore past decisions, instructions, guidelines or regulations and to secretly include and bury such claims in a filed cost report. This remains so whether or not a provider "wishes" to preserve a right to appeal disallowances that result if any such over charges are discovered.

D. Despite any Errors or Inconsistencies that may Appear in its Exhibits, the Complaint Properly States Claims upon which Relief may be Granted

Defendants argue that errors and purported inconsistencies and contradictions in how plaintiffs have highlighted the five volumes of exhibits that are attached to the Complaint render the entire pleading incapable of stating a claim for relief. As is explained more fully in the Declaration of Matthew Smith, which accompanies this pleading, the vast majority of the purported errors and

"inconsistencies" Quorum identifies are artifacts of its own analysis or misreading of the plain terms of the Complaint. Many also arise from defendants' incorrect assumption that plaintiffs' decision not to sue with respect to all reserve items is tantamount to a concession that all such items were properly made at the time the cost reports were filed.

Plaintiffs acknowledge, however, that some errors in highlighting (and accidental inconsistencies in highlighting between the multiple copies of the same set of exhibits that plaintiffs were required to prepare) were made. Where such errors have occurred, plaintiffs note that fact (see Smith Dec. and Exhibits) and have endeavored to correct the confusion by preparing and presenting a Master Claims Guide to the exhibits, which clarifies which reserve items are alleged to identify separate FCA violations that damaged the government. If the Court deems it necessary and appropriate, plaintiffs are prepared formally to add this exhibit to the Complaint so that any lingering confusion caused by real highlighting errors is alleviated. That some few such errors occurred in the process of highlighting multiple copies of 164 exhibits that set forth each of the thousands of false claims defendants submitted does not negate the overall sufficiency of the Complaint.

E. The Complaint Pleads False Claims Act Damages.

Defendants contend that plaintiffs' False Claims Act remedies should be limited to statutory penalties because the Complaint purportedly fails to allege that the government was damaged as a result of their alleged misconduct. See

Quorum's Consolidated Brf., at 31. Once again, it is difficult to comprehend how defendants could reach that conclusion based upon the actual allegations of the Complaint. At Paragraphs 29, 30, and 47 of the Complaint, plaintiffs explain how hospitals are compensated for costs reported in annual cost reports first through interim payments over the course of the hospital's fiscal year and then through year-end adjustments made after the cost reports are filed and based on the content thereof. Accord Calhoon, 97 F.3d at 522-23 ("To satisfy provider hospitals' cash requirements, the intermediaries paid [the provider] periodically throughout the fiscal year for estimated Medicare costs.... [Thereafter, after the provider filed its annual cost report], "the intermediaries determined the correct amount of Medicare reimbursement for the year and either paid [the provider] the amount due or billed it for excess interim payments."). The government's reliance -- for purposes of making "both interim and year-end payments" -- on the truthfulness of the statements defendants made in their filed cost reports is alleged at Paragraph 57 of the Complaint. The fact that defendants have been paid for the false claims at issue in this lawsuit is made clear as well by allegations of the Complaint specifically mentioning such payments,[12/] by allegations discussing the right of the United States to be "repaid" for improper items included in defendants' filed cost reports,[13/] by allegations noting that defendants "accepted reimbursement . . . for

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[12/] See, e.g., id., ¶¶ 144, 152, 159, 166, 192, 209, 223, 226, 251, 291, & 296.

[13/] See, e.g., id., ¶¶ 56 & 105.

more than they were entitled to receive,"[14] and by the allegation that the United States "suffered damages" as a result of defendants' false claims.[15]

Thus, fairly construed, the Complaint adequately alleges that damages resulted from defendants' fraud.

II. THE COMPLAINT SATISFIES FED. R. CIV. P. 9(b)'S REQUIREMENT THAT CIRCUMSTANCES CONSTITUTING FRAUD OR MISTAKE BE STATED WITH PARTICULARITY.

The purpose of Rule 9(b) requirement that "circumstances constituting fraud . . . be stated with particularity" is to insure that defendants are alerted to the precise misconduct with which they are charged and protected against spurious charges of fraudulent behavior. See Brooks v. Blue Cross & Blue Shield, 116 F.3d 1364, 1371 (11th Cir. 1997), quoting Seville Indus. Machinery Corp. Southmost Machinery Corp., 742 F.2d 786, 791 (3d Cir. 1984), cert. denied, 469 U.S. 1211, 105 S.Ct. 1179 (1985). It is important, however, not to construe Rule 9(b) in a vacuum. Focusing exclusively on Rule 9(b)'s "particularity" language "' is too narrow an approach and fails to take account of the general simplicity and flexibility contemplated by the rules.'" Seville, 742 F.2d at 791, quoting Christidis v. First Pennsylvania Mortgage Trust, 717 F.2d 96, 100 (3d Cir. 1983) and 5 C. Wright & A. Miller, Federal Practice and Procedure, Sec. 1298, at 407 (1969). Rule 9(b) must be read in conjunction with Rule 8(a), which requires that a plaintiff plead only a

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[14] See, e.g., id., ¶ 121.

[15] See, e.g., id., ¶¶ 323, 326 & 329.

short, plain statement of the grounds upon which he is entitled to relief. Brooks, 116 F.3d at 1371. Rule 9(b) is satisfied if defendants are given enough information to allow them to frame a responsive pleading and the Court is assured that an adequate basis exists for the charges made. Rich-Taubman Associates v. Stamford Restaurant Operating Co., Inc., 587 F. Supp. 875, 880 (S.D.N.Y. 1984). The complainant is not required to set forth every possible detail supporting his allegation, and he is not required to plead evidence. Schlick v. Penn-Dixie Cement Corp., 507 F.2d 374, 379 (2d Cir. 1974), cert. denied, 421 U.S. 976, 95 S.Ct. 1976 (1975), citing Brady v. Games, 128 F.2d 754, 755 (1942).

Quorum ignores the broader context and flexibility of the Rules of Federal Procedure and misstates Eleventh Circuit law when it asserts that "Rule 9(b) requires that a complaint state:

> (1) precisely what statements were made in what documents or oral representations or what oral (sic) omissions were made, and
>
> (2) the time and place of each such statement and the person responsible for making (or, in the case of omissions, not making) same, and
>
> (3) the content of such statements and the manner in which they misled the plaintiff, and
>
> (4) what the defendants 'obtained as a consequence of the fraud.'"

See Quorum Consolidated Brf, at 35-36, quoting Brooks v. Blue Cross & Blue Shield, 116 F.3d at 1371 (emphasis added). Although Brooks notes that Rule 9(b) "may be satisfied" if a complaint sets forth the list of particulars Quorum cites, immediately thereafter the Eleventh Circuit affirms that "'alternative means are also

available to satisfy the rule.'" Id., quoting Seville, 742 F.2d at 791. See also Durham v. Business Management Associates, 847 F.2d 1505, 1512 (11th Cir. 1988) (While "[a]llegations of date, time or place satisfy the Rule 9(b) requirement that the circumstances of the alleged fraud must be pleaded with particularity, ... alternative means are also available to satisfy the rule.") (emphasis in the original); Seville, 742 F.2d at 791 ("[A]llegations of 'date, place or time' fulfill [the purposes of Rule 9(b)], but nothing in the rule requires them. Plaintiffs are free to use alternative means of injecting precision and some measure of substantiation into their allegations of fraud.").

In a case alleging mail fraud, the Eleventh Circuit thus concluded that an affidavit -- submitted in opposition to a motion for summary judgment -- which generally identified the mailings at issue in the case added sufficient detail in support of the "conclusory" allegations of plaintiff's complaint to satisfy Rule 9(b). Durham, 847 F.2d at 1512 & nn. 11 & 12. Similarly, in Seville -- a case cited with approval by the Eleventh Circuit -- the Third Circuit found that a plaintiff satisfied Rule 9(b) by making allegations of fraud which, while not setting forth defendants' precise words, described generally the nature and subject of the alleged misrepresentations and which were supplemented with lists that identified the specific pieces of machinery that were subject to the allegedly fraudulent transactions. Seville, 742 F.2d at 791.

The approach plaintiffs have used to plead the current case is much akin to

that approved in Seville. Plaintiffs first described the nature of cost reporting in federal reimbursement programs and provided an overview of the rules and procedures that are most relevant to their claims. Plaintiffs then provided a detailed explanation of the improper policies and practices that informed defendants' preparation of their own cost reports and detailed descriptions and examples of each major category of claims with respect to which defendants submitted false claims. Thereafter, using reserve summaries and work papers that defendants themselves created to calculate the amount of reserves that would suffice to repay the Government if their overcharges were discovered, plaintiffs provided documentation identifying each and every currently-known claim for which liability is asserted. Finally, plaintiffs provided the basis for their contention that similar false claims likely were included in each of the other cost reports defendants prepared and filed, but with respect to which plaintiffs have not yet had opportunity to see or review reserve documentation. Certainly, such an approach puts defendants on notice of the wrongdoing that is alleged and negates any genuine concern that charges of fraud have been made without foundation.

It appears that defendants seek to transform Rule 9(b) into a rigid pleading trap in which any omission or mistake in pleading by plaintiffs' counsel will permit them to escape the consequences of their fraudulent activity. The Eleventh Circuit recognized, however, that the Federal Rules were designed to reject such an approach; the particularity directives of Rule 9(b) must be harmonized with the

broader policy of notice pleading. See, e.g., Friedlander v. Nims, 755 F.2d 810, 813 n.3 (11th Cir. 1985).

There is no merit to defendants' criticism of the Complaint for not focusing directly upon summary data in the filed cost reports in which the numerical entries representing defendants' false claims were encompassed. See Quorum Consolidated Brf., at 37. Because the reserve papers associated with the filed cost report identify the filed cost report at issue and provide specific information regarding the false claims made that would be impossible to identify from review of the filed cost report itself, plaintiffs' reliance upon the information exposed in the reserve papers to identify the specific items within the filed cost report that are at issue is entirely logical and appropriate. Likewise, the purported "failure" of the Complaint to identify which intermediary personnel ultimately reviewed and/or audited defendants' fraudulent cost reports, id., at p. 38, seeks to turn an immaterial fact into a technical hurdle that makes pleading fraud in complex cases exceedingly difficult without the corresponding benefit of providing any information that defendants genuinely need to answer the allegations against them. The Complaint explains that defendants' cost reports were reviewed by fiscal intermediaries retained by the Government to process reimbursement claims on its behalf. Complaint, at ¶¶ 28-32. Quorum's feigned inability to understand plain allegations of the Complaint notwithstanding, such information certainly is not something that a major hospital management chain needs to have spelled out for it in detail.

That some allegations are based upon information and belief is appropriate where, as here, the Complaint sets forth the facts upon which the belief is based and/or where additional details regarding the circumstances of a fraud are peculiarly within the opposing party's knowledge. See, e.g., Schlick, 507 F.2d at 379; Zatkin v. Primuth, 551 F. Supp. 39, 42 (S.D. Cal. 1982); Oleck v, Fischer, 401 F. Supp. 651, 655 (S.D.N.Y. 1975); 5 C. Wright & A. Miller, Federal Practice and Procedure: Civil 1298, at 416 (1969).[16/] Here, we alleged with particularity company-wide policies and practices that resulted in false claims and false statements, i.e., false certifications, see, e.g., United States ex rel. Thompson v. Columbia/HCA Healthcare Corp., 20 F.Supp. 2d 1017, 1046 (S.D. Tex. 1998), each time Quorum prepared and submitted a Medicare cost report on behalf of its owned and managed hospitals. In a FCA case alleging company-wide falsification of patient service records involving certain unnamed skilled nursing facilities, one court stated recently that

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[16/] Defendants contend that the Government's fiscal intermediaries had "both the means and responsibility to audit and obtain access to all underlying materials pertaining to the defendants' cost reports" and thus that any information and belief pleading in this case is unjustified. See Quorum Consolidated Brf., at 39. They are incorrect. As the Complaint alleges, at ¶ 52, and the Eleventh Circuit recognized in Calhoon, "[a]vailable time and resources do not permit audit of more than a fraction of cost reports filed." 97 F.3d at 529. Quorum's contention that the government can be barred by the Federal Rules of Civil Procedure from obtaining relief because it cannot plead in its Complaint all the details Quorum concealed about its misconduct amounts to little more than an assertion -- inconsistent with the Eleventh Circuit's ruling in Calhoon -- that it is entitled to turn the Medicare reimbursement system into "a cat and mouse game in which [it and other] clever providers [can], with impunity, practice fraud on the government." 97 F.3d at 529.

> [T]he first amended complaint places the defendants on fair notice of the allegation that their false claims for reimbursement are the result of corporate managerial and operational policies. The fact that plaintiffs are presently aware of only four nursing homes owned and operated by the defendants, and are thus only able to address the alleged fraud perpetrated in claims for those facilities, seems quite beside the point. Plaintiffs allege a corporate policy and thus allege by reasonable inference conduct at all homes owned or operated by the defendants. [Citations omitted]. The court is satisfied that given the allegations of control and given that the information concerning what other facilities exist is within the defendants' control, to require more specificity of these relators would frustrate the purposes of the False Claims Act.

United States ex rel. McKenzie v. Crestwood Hospitals, Inc., et al., No. CIV S-97-107 LKK/GGH (E.D. Cal. March 29, 1999) (order denying motions to dismiss) (attached). Similarly, it is reasonable to infer that Quorum followed its company-wide policies and practices in preparing and submitting cost reports for which plaintiffs have yet to obtain Quorum's reserve cost reporting documentation.

Plaintiffs have provided defendants with ample notice of the allegations against them from which to prepare an answer. There is no danger that this case would proceed upon the basis of allegations for which there is no foundation in fact. Quorum's fraud was so widespread and pervasive as to render suspect every cost report it prepared for its many owned and managed hospitals. The routine nature of Quorum's FCA violations should not serve to shield it from FCA liability.

III. QUORUM'S BULLET POINTS MISS THEIR TARGET.

On page 2 of their brief, defendants list four bullet-point criticisms of the

Complaint that they contend constitute "remarkable" failings in what should have been pled. Each criticism misses the mark in crucial respects:

First, Quorum complains that "the Complaint fails to identify any law or regulation prohibiting Quorum's allegedly fraudulent practice of using reserve accounts." See Quorum's Consolidated Brf., at 2. If, as seems to be suggested, Quorum means to imply that the Complaint contends that creation of reserves is an inherently fraudulent practice, it misstates the crux of plaintiffs' claim for the reasons set forth previously. It is not the creation of reserves that constitutes the wrong alleged, but the filing of cost reports that contain false claims and the concealment from Medicare of information necessary to permit them to accurately understand and evaluate the nature of the costs for which reimbursement was being sought. Given the policies Quorum employed in creating reserves and the specific content of Quorum's reserve papers, its reserve cost reports expose the false claims defendants submitted. They do not, however, constitute the false claims. If, on the other hand, Quorum means to imply that the Complaint does not cite reasons why the scheme actually alleged is unlawful, Quorum is incorrect. Paragraphs 33-67 of the Complaint spell out in great detail what legal duties Quorum violated.

Second, Quorum complains that "the Complaint fails to identify any legal duty requiring Quorum to submit with its cost reports copies of Quorum's reserve accounting workpapers." The Complaint alleges, however, that it is Quorum's "concealment of, or failure to disclose, the information contained in their reserve

sets of cost report records" that violates defendants' cost report certifications and duties. See Complaint, ¶ 5 (emphasis added); see also id., ¶ 86 (“Quorum took affirmative steps to conceal the financial information contained in its reserve cost reports . . . .”)(emphasis added). This distinction -- which defendants also ignore when they quote and paraphrase Paragraph 5 of the Complaint at page 9 of their brief -- is important because the duty alleged is to provide "such information to the intermediary as may be necessary to ... [a]ssure proper payment by the program" and to "provide adequate cost data." Id., ¶ 61 (quoting 42 C.F.R. §§ 413.20(d) & 413.24(a)). Because Quorum's reserve work papers expose information that contradicts the claims for cost reimbursement Quorum submitted in its filed cost reports, and because Quorum’s use of such information to recalculate reimbursement and create reserves demonstrates that Quorum withheld or concealed that information from Medicare and its intermediaries, the reserve work papers constitute substantial evidence that Quorum knowingly violated its duty to share all relevant information with Medicare when seeking such reimbursement. Providing the intermediary with its reserve work papers would have gone a long way toward fulfilling Quorum's obligations to provide candid and complete information, but the heart of the matter is the withholding of the relevant information itself.

Third, Quorum complains that the Complaint fails to provide any facts supporting its contention that the highlighted materials in Exhibits 32-196 of the Complaint constitute evidence of Quorum's "nationwide and longstanding

submissions of false claims and false records to the government...." Again, Quorum's representation is simply not true. The factual basis for plaintiffs' information and belief pleading, based upon reasonable inferences from the evidence presently available to plaintiffs, is plainly presented in the Complaint and explained in great detail in the description and analysis of the Complaint provided above.

Finally, Quorum complains that there are a "significant number of inconsistencies and contradictions among the highlighted reserves and between the highlighted reserves and those hundreds of reserves which the Complaint admits are not culpable . . . which render the Complaint illogical and unfounded." As explained more fully in the Declaration of Matthew Smith which accompanies this brief, the purported "inconsistencies and contradictions" Quorum identifies are mostly the result of defendants' misunderstanding of the Complaint. Given the tremendous volume of highlighting that was required, however, some errors were made both in creating the master copies of the exhibits or in the process of recreating the many service copies of the exhibits that plaintiffs were required to prepare. To clear up confusion about what reserve items were intended to be highlighted to indicate specific false claims, plaintiffs are filing with their brief the Declaration of Marie V. O'Connell and the Declaration of Peter Chatfield, which has attached to it a Master Claims Guide pertaining to Exhibits 32-196, that should remove any confusion caused by highlighting errors and omissions. If the Court deems it

necessary and appropriate, plaintiffs will amend their Complaint to add this clarifying document as an exhibit to that pleading.

IV. THE GOVERNMENT HAS PROPERLY STATED COMMON LAW AND EQUITABLE CLAIMS FOR RELIEF.

Quorum devotes three pages of its brief to passing assertions that the fourth, fifth, sixth, seventh and eighth causes of action, in which the Government states its common law and equitable claims, fail to state claims for relief. See Quorum Consolidated Brf., at 32-35. In this section of plaintiffs' response, the United States responds seriatim to Quorum's assertions.

Quorum states that the fourth cause of action, for unjust enrichment, fails to specify the nature of the benefits unjustly retained, the hospital which received the benefits, or the amounts at issue. See Quorum Consolidated Brf., at 32. To the contrary, it was alleged or can be reasonably inferred from the Complaint that Quorum's owned hospitals, identified in Exhibit 4 to the Complaint, filed cost reports that enabled these hospitals to obtain inflated cost reimbursement in the amount of the non-allowable cost items identified in the corresponding reserve cost report documents. See, e.g., Complaint, at ¶¶ 56, 105, 121, 144, 152, 159, 166, 192, 209, 223, 226, 251, 291, 296, 323, 326 & 329.

Quorum states that the fifth cause of action, payment by mistake, fails to specify the payments mistakenly made to specific hospitals. See Quorum Consolidated Brf., at 32. Once again, the payments made by mistake are those specifically identified by Quorum in its reserve cost reporting documents. See, e.g.,

Complaint, at ¶¶ 56, 105, 121, 144, 152, 159, 166, 192, 209, 223, 226, 251, 291, 296, 323, 326 & 329.

Quorum states that the sixth cause of action, disgorgement of unlawful profits, cannot state a separate claim for relief. See Quorum Consolidated Brf., at 33. Quorum is incorrect; disgorgement is "an equitable remedy, not a request for money damages." United States ex rel. Zissler v. Regents of the University of Minnesota, 992 F.Supp. 1097, 1109 (D. Minn. 1998). In Zissler, the court permitted the separate count for disgorgement to proceed, ruling only that a statute of limitations, 28 U.S.C. § 2415(a), did not apply to an equitable claim for disgorgement of illegal profits. Id.

Quorum states that the seventh cause of action, common law fraud, fails to state a claim because of purportedly insufficient allegations of reliance and damages. See Quorum Consolidated Brf., at 33-34. The United States' reliance upon Quorum's false certifications of the truth, correctness and completeness of its filed cost reports is specifically alleged in Paragraph 57 of the Complaint. That damages resulted from this justifiable reliance is alleged in, or can be reasonably inferred from, many paragraphs of the Complaint. See, e.g., Complaint, at ¶¶ 56, 105, 121, 144, 152, 159, 166, 192, 209, 223, 226, 251, 291, 296, 323, 326 & 329.

Quorum states that the eighth cause of action, common law recoupment, is defensive in nature and cannot be stated as a separate claim for relief. See Quorum Consolidated Brf., at 34-35. It is true that common law recoupment may be

raised defensively. Nonetheless, it is well-settled that the Government may maintain a "direct suit," such as this, for improperly paid Government funds. United States v. Wurts, 303 U.S. 414, 415 (1938); Mount Sinai Hospital of Greater Miami, Inc. v. Weinberger, 517 F.2d 329, 337 (5th Cir. 1975).

There is no merit to Quorum's passing assertions that the Government has failed to state common law and equitable claims for relief.

V. EVEN IF THE COMPLAINT COULD BE IMPROVED, DISMISSAL IS NOT THE APPROPRIATE REMEDY.

Even if the Court determines that improvements should be made to the Complaint before defendants are required to answer, dismissal is not appropriate "unless it appears beyond doubt that the plaintiff can prove no set of facts in support of his claims which would entitle him to relief." Conley, 355 U.S. at 45-46, 78 S.Ct. at 101-102. The Eleventh Circuit's "strict adherence to this rule has led [it] to hold that a district court should give a plaintiff an opportunity to amend his complaint rather than dismiss it when it appears that a more carefully drafted complaint might state a claim upon which relief could be granted." Friedlander, 755 F.2d at 813; Dussouy v. Gulf Coast Investment Corp., 660 F.2d 594, 597-99 (5th Cir. 1981). Where a complaint properly states some claims for relief but includes other allegations that do not satisfy Rule 9(b), dismissal of the entire pleading is clearly unwarranted. A more appropriate remedy in such circumstances is a Rule 12(e) request for a more definite statement with respect to the offending allegations. See Guam Investment Company v. Central Building, Inc., 288 F.2d 19, 24 (9th Cir.

1961).[17/] Even Rule 12(e) should be used only where the specific allegations fail to provide a defendant sufficient basis to plead in response. Sisk v. Texas Parks and Wildlife Dept., 644 F.2d 1056, 1059 (5th Cir. 1981). Where a pleading meets that standard, the proper avenue for eliciting evidentiary detail is discovery. See, e.g., Bazal v. Belford Trucking Co., Inc., 442 F. Supp. 1089, 1101-02 (S.D. Fla. 1977).

Defendants argue that plaintiffs should not be given an opportunity to correct any material pleading flaws the Court finds in the Complaint because earlier amendments were made to the Complaint when both Quorum and Columbia/HCA were defendants in a single action under seal. Quorum's current motion, however, is the first challenge that has been raised to the sufficiency of plaintiffs' pleading. Rule 15(a) provides that leave to amend "shall be freely given when justice so requires." Plaintiffs have stated legitimate grounds which, if proven, would entitle them to relief from an extensive pattern of fraud. It would not be in the interest of justice to permit defendants to keep the windfall of their misconduct before granting plaintiffs an opportunity to correct any technical shortcomings found in the Complaint.

CONCLUSION

For the reasons cited above, defendants' Rule 12(b)(6) and Rule 9(b) consolidated motions to dismiss the False Claims Act, common law and equitable causes of action contained in plaintiffs' Complaint should be denied.

[17/] To the extent that errors in highlighting the Complaint's exhibits created confusion, we have addressed that, consistent with Rule 12(e), by submitting with these papers a Master Claims Guide that corrects such errors.

Respectfully submitted,

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